STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY STREET LAKE STATION, IN46405

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R0000	This visit was for the Post Survey Revisit to the State Licensure Survey completed on May 11, 2011. Survey Date: August 1, 2011 Facility Number: 001136 Provider Number: 001136 AIM Number: N/A Surveyor Heather Tuttle, R.N. T.C. Census Bed Type: 128 Residential 128 Total Census Payor Type: 128 Other 128 Total Sample: 11 These State Residential Findings are cited in accordance with 410 IAC 16.2.	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0050	(t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident ' s funds given the facility for safekeeping; (5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars ($100) in an interest-bearing account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars ($100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s			

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	legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds; (10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident ' s estate.			
	Based on record review and interviews, the facility failed to ensure every resident received interest on their money for funds greater than 100.00 dollars for 5 of 5 residents reviewed for funds in the sample of 11. (Residents #7, #8, #9, #10, and #11) Findings include: Review of the Resident Funds account on 8/1/11 at 1:00 p.m., indicated the following: Resident #7 had $221.21 in the account. Resident #8 had $1350.12 in the account.	R0050	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #7 no longer resides in the facility. Resident#8 has interest allocated. Resident#9 no longer resides in the facility. Resident#10 has interest allocated. Resident#11 has interest allocated. Interest was allocated for January 2009 to July 2011 for residents who had balances greater than one hundred (100.00) dollars. Resident #7 and 11 have been discharged from the community and the interest has been allocated for the time they resided in the facility and had	09/15/2011

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	Resident #9 had $286.00 in the account. Resident #10 had $355.74 in the account. Resident #11 had $357.21 in the account. Review of the 2009 and 2010 bank statements for each of the above mentioned residents indicated no interest had been credited to their accounts. Earned interest was credited to the above residents' accounts on 12/9/08. No interest had been credited to any of the residents' accounts for 2011. Review of the Admission Packet provided by the Administrative Assistant on 8/1/11 at 3:00 p.m., indicated a "Consent Treatment" form which indicated the Authorization for Resident Fund Handling. This form indicated, "The undersigned does hereby grant to the facility permission to execute the financial affairs of the above designated resident. The authorization may apply to all financial affairs except as is herein designated (limitations). It has been explained to me that with the granting of this of this authorization, the facility shall provide a quarterly accounting of affairs handled according to the written records of these transactions and return of remaining funds within fifteen (15) days subsequent to receipt of written request for same. The authorization shall be valid for the period of time in which I am in		balances greater than one hundred (100.00) dollars. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents of Lake Park Residential who have balances greater than one hundred (100.00) dollars in in resident fund accounts have the potential to be affected by this alleged deficient practice. All residents with co-op accounts or who have Lake Park manage their funds will be given the Authorization for Resident Funds Handling that will require their signature of authorization. The Authorization for Resident Fund Handling has been updated and will remain a form in the Admission Packet for Lake Park Residential. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?The resident funds will remain in an interest bearing account. The Corporate account who prepares the bank reconciliation will run a Summary Report as of the end of the month. The interest earned from the interest bearing account will be allocated, one cent each, to the residents with the balances of one hundred dollars or more until the interest has been exhausted. Should interest rate increase so that the earnings exceed more	

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	residence at this facility unless a specified expiration date is herein requested (expiration date, if any)" Review of the Admission Business files for the above mentioned residents indicated none of them had signed this document regarding resident funds. Review of the Plan of Correction indicated "The Corporate office that is handling the interest to be credited will be inserviced on the regulations regarding personal fund accounts. The Business Office Manager that handles the resident personal fund accounts in the facility will be inserviced on the regulation. The Business office manager will ensure the interest has been credited to resident person fund accounts in excess of one hundred ($100) dollars on a quarterly basis." Interview with the Corporate Manager on 8/1/11 at 1:00 p.m., indicated the corporation was instructed in 2007 to place the resident funds into an interest bearing account. At that time, all of the funds were transferred to an interest bearing account. She further indicated the bank started charging the corporation monthly service fees and these fees were greater than the interest being earned monthly. She also indicated the		than one cent with balances more than one hundred, the account will allocate the earnings on a ratio of each's balance to the total of all residents balance greater than one hundred (100.00) dollars. Any service charges made by the bank will be paid by Lake Park Residential. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur? The accountant preparing the bank reconciliation will be in-serviced on how to allocate the interest to resident accounts. The controller will review the allocation entry and will send the report to the Administrator with notification of the allocation and the residents' balances. The Business Office Manager and the Administrator will monitor the resident fund accounts monthly to ensure that the interest has been added to resident balances greater than one hundred (100.00) dollars. The Business Office Manager in conjunction with the Corporate Account and Controllers Office will ensure that residents receive quarterly statements and the Administrator will monitor for compliance. The Corporate accountant and Controller willbe inserviced on maintaining resident funds in an interest bearing account. Monitoring will be ongoing. 5.By what date the systemic changes will be completed? Systemic changes will be completed by September	

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	corporation did not credit any of the residents any interest in 2009 or 2010 and for 2011. She indicated they used the interest earned from the resident accounts to pay the monthly service fee in 2009, 2010, and 2011. She indicated the monthly service fees the bank was charging was greater than the interest being earned. Interview with the Business Office Manager on 8/1/11 at 1:00 p.m., indicated none of the residents with bank accounts greater than 100.00 dollars had received any interest from the two years past as of 7/31/11. She also indicated at the time, that she did not know if the residents received quarterly statements. Interview with the Administrator on 8/1/11 at 1:00 p.m., indicated she was unaware the corporation was not crediting the resident accounts with their interest earned from their money. She also indicated she was unaware the corporation was using the interest earned to pay the monthly service fee being charged by the bank. This State Residential Rule was cited on 5/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence.		15, 2011.	

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R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure a licensed nurse was monitoring and supervising the administration of medications and residential nursing care as ordered by the physician related to insulin administration and blood glucose testing for 3 of 11 sampled residents reviewed for following physician orders. (Residents #2, #3, & #4) Findings include: 1. The record for Resident #2 was reviewed on 8/1/11 at 2:15 p.m. The resident's diagnoses included but were not limited to non-insulin diabetes. Review of Physician orders, dated 7/2/11, indicated blood glucose monitoring on Mondays, Wednesdays, and Fridays at 4:00 p.m. Review of the Finger Stick Blood Glucose Monitoring/Sliding Scale Insulin coverage Administration Record for the month of July 2011 indicated a blood glucose was obtained only one time on July 18, 2011 at 5:00 p.m. There were two readings recorded that day. There was no other blood glucose readings for the rest of the month. Interview with LPN #1 on 8/1/11 at 2:30 p.m.,	R0241	1. What corrective actions will be accomplished for those residents affected by the deficient practice?Resident#2 is not in facility at this time.Resident#3's blood glucose monitoring has been performed and documented.Resident#4 no longer resides in the facility.2. How will the facility identify other residents having the potential to be affected by the same deficient practice?All residents with orders for blood glucose monitoring have the potential for being affected by this deficient practice. Residents with blood glucose monitoring records are being audited by the Director of Nursing and or designee.3. What measures are being put into place or what systemic changes the facility will make to ensure that the deficient praactice does not recur?A directed in-service has been conducted with all the nurses including the Director of Nursing, responsible for nursing care in the facility.Competency testing has been conducted with all the nurses including the Director of Nursing, responsible for the nursing care in the facility and the	09/15/2011

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	indicated there were no other blood sugars taken for the entire month. She indicated the resident often refuses; however, there was no documentation in the resident's record of any type of refusals. The Director of Nursing was not in the facility and was unavailable for interview. 2. The record for Resident #3 was reviewed on 8/1/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, diabetes. Review of Physician orders, dated 7/2/11, indicated Blood Glucose Monitoring twice a day at 6:00 a.m., and 4:00 p.m. Further review of Physician orders indicated the resident was to receive Novolin Insulin 70/30, 35 units every morning before breakfast. Review of the Finger Stick Blood Glucose Monitoring/Sliding Scale Insulin coverage Administration Record for the month of July 2011 indicated a blood glucose was obtained at 4:00 p.m. only on 7/4, 7/5, 7/12-7/14, 7/18-7/22, 7/24-26, and 7/28-7/30. Further review of the Blood Glucose Monitoring Record indicated there was no Blood glucose obtained on 7/2, 7/3, 7/6, 7/7, 7/8, 7/15, 7/16, 7/27, and 7/31/11. Interview with LPN #1 on 8/1/11 at 2:30 p.m., indicated the resident's blood sugars were not obtained at 6:00 a.m., as ordered by the physician and some were not obtained at all. The Director of Nursing was not in the facility and was unavailable for interview. 3. The record for Resident #4 was reviewed on 8/1/11 at 11:45 a.m. The resident's diagnoses		results have been placed in the Admnistrator's office.A re-designed blood glucose monitoring form has been instituted for nurses to document blood glucose monitoring.4. How the corrective actions will be monitored to ensure the deficient practice will not recur? The Director of Nursing and/or designee audit blood glucose montioring forms on a daily basis to ensure that moniroting is being done as ordered. Monitoring will be on-going.5. By what date the systemic changes will be completed? September 15, 2011.	

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	included, but were not limited to, diabetes. Review of Physician orders, dated 9/20/10 and on the current 8/11 recap, indicated Lantus insulin 10 units at bedtime. The resident also had orders for an insulin sliding scale of Novolog dated 9/20/10 and on the current 8/11 recap, as follows: 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and greater than 400=12 units. Another Physician order, dated 7/2/1,1 indicated Blood Glucose monitoring twice a day at 6:00 a.m., and 4:00 p.m. Review of the Finger Stick Blood Glucose Monitoring/Sliding Scale Insulin coverage Administration Record for the month of July 2011 indicated a blood glucose was obtained at 5:00 on the following days: 7/3, 7/7, 7/8, and 7/10/11. There was no other blood glucose testing done for that resident. The resident's blood glucose was only obtained four times in the month of July 2011. Review of the Plan of Correction indicated the Director of Nursing or designee will perform random audits of resident records on a weekly basis to ensure the compliance with blood glucose testing. Review of the Plan of Correction Book provided by the Administrator indicated a staff educational inservice on 6/2/11 for accuchecks and blood glucose monitoring. The details and content indicated "All residents with orders for blood glucose monitoring must have blood glucose monitoring done as ordered. If a resident is given orders for blood glucose that is not specific and open to interpretation, nurse must repeat the order			

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	back to the physician for clarification. All blood glucose monitoring performed must be recorded in resident's record. Time blood glucose monitoring done must also be recorded." Interview with the Administrator on 8/1/11 at 2:45 p.m., indicated there was documentation of any weekly blood glucose monitoring audits performed by the Director of Nursing. Interview with LPN #1 on 8/1/11 at 2:30 p.m., indicated there were no other blood glucose results for the resident because staff did not do blood glucose test. She indicated the resident often refused, however, there was no documentation in the resident's record indicating any type of refusals. The Director of Nursing was not in the facility and was unavailable for interview. This State Residential Rule was cited on 5/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			